

(continued)

14. Screen for behavioral and social-emotional problems per “Promoting Optimal Development: Screening for Behavioral and Emotional Problems” (<https://doi.org/10.1542/peds.2014-3716>), “Mental Health Competencies for Pediatric Practice” (<https://doi.org/10.1542/peds.2019-2757>), “Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders” (<https://pubmed.ncbi.nlm.nih.gov/32439401>), “Screening for Anxiety in Adolescent and Adult Women: A Recommendation From the Women’s Preventive Services Initiative” (<https://pubmed.ncbi.nlm.nih.gov/32510990>), and “Anxiety in Children and Adolescents: Screening” (<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-anxiety-children-adolescents>). The screening should be family centered and may include asking about caregiver emotional and mental health concerns and social determinants of health, racism, poverty, and relational health. See “Poverty and Child Health in the United States” (<https://doi.org/10.1542/peds.2016-0339>), “The Impact of Racism on Child and Adolescent Health” (<https://doi.org/10.1542/peds.2019-1765>), and “Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health” (<https://doi.org/10.1542/peds.2021-052582>).
15. A recommended tool to assess use of alcohol, tobacco and nicotine, marijuana, and other substances, including opioids is available at <http://craftt.org>. If there is a concern for substance or opioid use, providers should consider recommending or prescribing Naloxone (see <https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf> and <https://nida.nih.gov/publications/naloxone-opioid-overdose-life-saving-science>).
16. Screen adolescents for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See “Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management” (<https://doi.org/10.1542/peds.2017-4081>), “Mental Health Competencies for Pediatric Practice” (<https://doi.org/10.1542/peds.2019-2757>), “Suicide and Suicide Attempts in Adolescents” (<https://doi.org/10.1542/peds.2016-1420>), and “The 21st Century Cures Act & Adolescent Confidentiality” (https://adolescenthealth.org/press_release/naspag-sahm-statement-the-21st-century-cures-act-adolescent-confidentiality/).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See “Use of Chaperones During the Physical Examination of the Pediatric Patient” (<https://doi.org/10.1542/peds.2011-0322>).
18. These may be modified, depending on entry point into schedule and individual need.
19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Screening Panel (<https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html>), as determined by The Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (<https://www.babysfirsttest.org/>) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See “Clinical Practice Guideline Revision: Management of Hyperbilirubinemia in the Newborn Infant 35 or More Weeks of Gestation” (<https://doi.org/10.1542/peds.2022-058859>).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per “Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease” (<https://doi.org/10.1542/peds.2011-3211>).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at <https://publications.aap.org/redbook/pages/immunization-schedules>. Every visit should be an opportunity to update and complete a child’s immunizations.
24. Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter).
25. For children at risk of lead exposure, see “Prevention of Childhood Lead Toxicity” (<https://doi.org/10.1542/peds.2016-1493>) and “Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention” (https://www.cdc.gov/nceh/lead/docs/final_document_030712.pdf).

26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
28. See “Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents” (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.
30. Screen adolescents for HIV at least once between the ages of 15 and 21, making every effort to preserve confidentiality of the adolescent, as per “Human Immunodeficiency Virus (HIV) Infection: Screening” (<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening>); after initial screening, youth at increased risk of HIV infection should be retested annually or more frequently, as per “Adolescents and Young Adults: The Pediatrician’s Role in HIV Testing and Pre- and Postexposure HIV Prophylaxis” (<https://doi.org/10.1542/peds.2021-055207>).
31. Perform a risk assessment for hepatitis B virus (HBV) infection according to recommendations per the USPSTF (<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-screening>) and in the 2021–2024 edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*, making every effort to preserve confidentiality of the patient.
32. All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF (<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening>) and Centers for Disease Control and Prevention (CDC) recommendations (<https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm>) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually.
33. Perform a risk assessment, as appropriate, per “Sudden Death in the Young: Information for the Primary Care Provider” (<https://doi.org/10.1542/peds.2021-052044>).
34. See USPSTF recommendations (<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening>). Indications for pelvic examinations prior to age 21 are noted in “Gynecologic Examination for Adolescents in the Pediatric Office Setting” (<https://doi.org/10.1542/peds.2010-1564>).
35. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (<https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/>) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See “Maintaining and Improving the Oral Health of Young Children” (<https://doi.org/10.1542/peds.2022-060417>).
36. Perform a risk assessment (<https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/>). See “Maintaining and Improving the Oral Health of Young Children” (<https://doi.org/10.1542/peds.2022-060417>).
37. The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption (<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1>). Once teeth are present, apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office based on caries risk. Indications for fluoride use are noted in “Fluoride Use in Caries Prevention in the Primary Care Setting” (<https://doi.org/10.1542/peds.2020-034637>).
38. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See “Fluoride Use in Caries Prevention in the Primary Care Setting” (<https://doi.org/10.1542/peds.2020-034637>).

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This schedule reflects changes approved in December 2023 and published in April 2024. For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

FOOTNOTE CHANGES MADE IN DECEMBER 2023

• 3-5 DAY VISIT (Footnote 4)

This footnote reflects the AAP “[Policy Statement: Breastfeeding and the Use of Human Milk](#)”, published June 2022.

• BODY MASS INDEX (Footnote 5)

This footnote reflects the AAP “[Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents with Obesity](#)”, published January 2023.

• BEHAVIORAL/SOCIAL/EMOTIONAL SCREENING (Footnote 14)

This footnote reflects the USPSTF “[Anxiety in Children and Adolescents: Screening](#)” recommendations, published October 2022.

• TOBACCO, ALCOHOL, OR DRUG USE ASSESSMENT (Footnote 15)

This footnote reflects the Centers for Disease Control (CDC) and National Institute of Drug Abuse (NIDA) guidelines related to recommending and prescribing Naloxone.

• NEWBORN BILIRUBIN SCREENING (Footnote 21)

This footnote reflects the AAP “[Clinical Practice Guideline Revision: Management of Hyperbilirubinemia in the Newborn Infant 35 or More Weeks of Gestation](#)”, published August 2022.

• ORAL HEALTH (Footnotes 35 and 36)

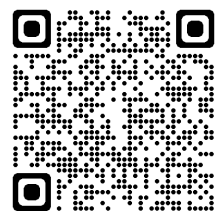
These footnotes reflect the AAP clinical report, “[Maintaining and Improving the Oral Health of Young Children](#)”, published December 2022.

CHANGES MADE IN DECEMBER 2022

HIV

The HIV screening recommendation has been updated to extend the upper age limit from 18 to 21 years (to account for the range in which the screening can take place) to align with recommendations of the US Preventive Services Task Force and AAP policy (“Adolescents and Young Adults: The Pediatrician’s Role in HIV Testing and Pre- and Postexposure HIV Prophylaxis”).

- Footnote 30 has been updated to read as follows: “Screen adolescents for HIV at least once between the ages of 15 and 21, making every effort to preserve confidentiality of the adolescent, as per ‘Human Immunodeficiency Virus (HIV) Infection: Screening’ (<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening>); after initial screening, youth at increased risk of HIV infection should be retested annually or more frequently, as per ‘Adolescents and Young Adults: The Pediatrician’s Role in HIV Testing and Pre- and Postexposure HIV Prophylaxis’ (<https://doi.org/10.1542/peds.2021-055207>)”



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